SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0742

Request for Reinstatement - Title II

Claimant's Name	Claim Number
Wage Earner's Name	

I request reinstatement of my Social Security Disability Benefits. I am disabled and my impairment is the same as (or related to) the impairment which was the basis for my prior entitlement. I am not performing substantial gainful activity (SGA) and my medical condition prevents me from performing SGA.

I understand that I may be able to receive provisional (temporary) benefits while my request for reinstatement is being decided.

For persons who have extended medicare coverage :

I understand that my Medicare coverage (Part A hospital insurance and Part B medical insurance) could terminate if my request for reinstatement is denied.

For persons who are entitled to any other SSA benefits based on disability or blindness:

I understand that if SSA denies my request for reinstatement because I have medically improved, my current entitlement to SSA benefits will be reviewed and may terminate.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature	Date	Area Code and Telephone Number Where You Can Be Reached During the Day
Address (Number and Street)		
City and State		ZIP Code

WITNESSES (Write in ink)

Witnesses are required ONLY if this request has been signed by mark (x) above. If signed by mark (x), two witnesses to the signing who know the applicant must sign below, giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State and ZIP Code)	Address (Number and Street, City, State and ZIP Code)

THIS INFORMATION IS ONLY NEEDED IF YOUR PROVISIONAL BENEFITS WILL BE SENT TO YOUR PRIOR REPRESENTATIVE PAYEE
REPRESENTATIVE PAYEE (Write in ink)

Your Title or Relationship to the Claimant	Area Code and Telephone Number Where You Can Be Reached During the Day
Address (Number, Street)	
City and State	ZIP Code

Your full name (First name, middle initial, last name) **Please print here**	Signature **Please sign here**	Date

Collection and Use of Personal Information

Sections 202(b), 202(c), 202(d), 202(e), 202(f), 205(a), 223 and 1872 of the Social Security Act, as amended, authorize us to collect this information. The information you provide will be used to determine if you or your dependents are entitled to insurance coverage and/or monthly benefits.

The information you furnish on this form is voluntary. However, failure to provide all or part of this information could prevent an accurate and timely decision on your request, and could result in the loss of some benefits or insurance coverage.

We rarely use the information you supply for any purpose other than for determining entitlement. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and

4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

Additional information regarding this form, routine uses of information, and our programs and systems, is available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act - This information collection meets the requirement of U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 2 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778)**. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***